

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

Reg. Dist. No. 64

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg</b>   |  | c. LENGTH OF STAY IN 1b<br><b>8 months</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Brooklyn Avenue</b>  |  |   |  | d. STREET ADDRESS<br><b>Brooklyn Avenue</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Barbara</b> Middle <b>Ann</b> Last <b>Brown</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>3</b> Year <b>19 57</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 1, 1956</b>  |  |
| 9. AGE (In years last birthday)<br><b>1</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.                                      |  | IF UNDER 24 HRS.<br>Hours <b>1</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pocomoke City, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>William Brown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Arlene Hunter</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>William Brown, Federalsburg, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mal Nutrition</b><br><b>286.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Probably Premature at Birth</b><br>DUE TO (c) <b>—</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1</b><br><b>1</b> Cause Birth                     |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Dawson O. George</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED <b>12/3/57</b>  |  |
| EXAMINER'S NAME (Type) <b>Dawson O. George, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Dec. 7, 1957</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Federal Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Federalsburg, Maryland</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>  |  |   |  | ADDRESS<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>12-5-57</b>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Margaret H. Frampton</b>   |  |   |  |

STATE OF NEW YORK  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                  |  |                |  |                |  |                 |  |                         |  |                |  |
|------------------|--|----------------|--|----------------|--|-----------------|--|-------------------------|--|----------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX            |  | RACE            |  | DATE OF DEATH           |  | PLACE OF DEATH |  |
| JAMES J. HARRIS  |  | 45             |  | M              |  | W               |  | 12-15-57                |  | NEW YORK       |  |
| RESIDENCE        |  | OCCUPATION     |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | MEDICAL HISTORY         |  | POST-MORTEM    |  |
| 1234 5th Ave.    |  | Teacher        |  | Heart Disease  |  | Natural         |  | Hypertension            |  | None           |  |
| FATHER           |  | MOTHER         |  | SIBLINGS       |  | MARRIAGE        |  | PREVIOUS ILLNESS        |  | TREATMENT      |  |
| John J. Harris   |  | Mary J. Harris |  | None           |  | 1950            |  | Coronary Artery Disease |  | Medication     |  |
| BORN             |  | DIED           |  | AGE            |  | SEX             |  | RACE                    |  | DATE OF DEATH  |  |
| 1912             |  | 1957           |  | 45             |  | M               |  | W                       |  | 12-15-57       |  |

**RECEIVED**  
 DEC 6 1957  
 BUREAU V. S.

STATE OF NEW YORK  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12929

12929

12922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 62

|   |                              |   |   |   |   |   |                                      |
|---|------------------------------|---|---|---|---|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> <b>MARYLAND</b>  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |   |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Denton</b>   |                              |   | c. LENGTH OF STAY IN 1b<br><b>6 mos.</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>x2 Ridgely</b> |   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                              |   |   | d. STREET ADDRESS<br><b>1</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Stella</b> Middle <b>Edith</b> Last <b>Diefenderfer</b>   |                              |   |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>24</b> Year <b>19 57</b>   |   |   |                                      |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 8, 1877</b>   |   | 9. AGE (In years last birthday)<br><b>80</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewifw</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |
| 13. FATHER'S NAME<br><b>William Biddle</b>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia ( unknown)</b>  |   |   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                              | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Mrs. Samuel Jopp, Denton, Md.</b>   |   |   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer Uterus (Cervix)</b><br><b>171X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b><br>(b) DUE TO<br>(c) DUE TO |                              |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>16 mo</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b>   |                              |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                              |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |   | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <b>Jan 28, 1946</b> to <b>Dec 24, 1957</b> , that I last saw the deceased alive on <b>Dec 22, 1957</b> at <b>12:30 A</b> M, from the causes and on the date stated above.<br>and that death occurred at <b>Denton, Md</b><br>ADDRESS (Street, city or town, state) DATE SIGNED    |                              |   |   |   |   |   |                                      |
| ACTUAL SIGNATURE<br><b>E. Paul Knotts</b>   |                              |   | M.D. <b>Denton, Md</b>  |   |   |   |                                      |
| PHYSICIAN'S NAME (Type)<br><b>E. Paul Knotts M.D.</b>   |                              |   |   |   |   |   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>Dec 27 1957</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ridgely</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Ridgely, Md.</b>                              |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Moore Denton</b>  |                              |   |   | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>12/27/57</b>   |                                      |
|   |                              |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>George Moore</b>   |   |   |                                      |

CERTIFICATE OF DEATH

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| DATE OF DEATH          |  | PLACE OF DEATH         |  |
| TIME OF DEATH          |  | MANNER OF DEATH        |  |
| CAUSE OF DEATH         |  | DISEASE OR INJURY      |  |
| AGE                    |  | SEX                    |  |
| RACE                   |  | RELIGION               |  |
| BIRTH DATE             |  | BIRTH PLACE            |  |
| MARRIAGE DATE          |  | MARRIAGE PLACE         |  |
| EDUCATION              |  | OCCUPATION             |  |
| PREVIOUS ILLNESS       |  | TREATMENT              |  |
| DATE OF BURIAL         |  | PLACE OF BURIAL        |  |
| SIGNATURE OF DECEASED  |  | SIGNATURE OF WITNESSES |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF CORONER   |  |
| SIGNATURE OF JUDGE     |  | SIGNATURE OF CLERK     |  |

BUREAU V. 8

DEC 30 1957

RECEIVED

## 12930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

62

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b><br>c. LENGTH OF STAY IN 1b <b>6mos.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Rural, Goldsboro</b><br>d. STREET ADDRESS <b>/</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Franklin</b> Last <b>Gove</b>   |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>5</b> Year <b>1957</b>  |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Jan 22, 1882</b>                             |
| 9. AGE (In years last birthday) <b>75</b> yrs.  |   | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>15</b>  | IF UNDER 24 HRS.<br>Hours <b>15</b> Min. <b>00</b>               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) <b>Penna.</b>          |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 13. FATHER'S NAME <b>Wilfred Gove</b>  |  |
| 14. MOTHER'S MAIDEN NAME <b>Emma Cooper</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT <b>Mrs. Janet C. Gove, Goldsboro, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Arteriosclerosis</b><br>(c) <b>Coronary Arteriosclerosis</b><br>DUE TO <b>Coronary Arteriosclerosis</b><br>cause lost.  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>1 yr</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |  |  |
| ACTUAL SIGNATURE <b>Dawson O. George</b>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>DAWSON O. GEORGE</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |   | 22b. DATE THEREOF <b>Dec. 9, 1957</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>West Laurel Hill</b>  |   | 22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. King</b>   |   | ADDRESS <b>honorable Denton, Kd</b>  |  |
| 24a. REC'D BY REGISTRAR <b>DATE 12/6/57</b>   |   | 24b. REGISTRAR'S SIGNATURE <b>Wm O George</b>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 9 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924

12931

## CERTIFICATE OF DEATH

Reg. Dist. No.

61

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caroline</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greensboro</u>  | c. LENGTH OF STAY IN 1b<br><u>2 yrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X2 Denton</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   | d. STREET ADDRESS<br><u>1</u>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARTIN</u> Middle <u>BATES</u> Last <u>HENRY</u>   |   | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>30</u> Year <u>1957</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>            | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>SEPT 25, 1875</u>  |
| 9. AGE (In years last birthday)<br><u>82</u> yrs.  |   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   | IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>BLACKSMITH</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SMITHING</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>JAMES L HENRY</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>ADELINE CARROLL</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>MRS WM. PARKS</u>  |   | Address<br><u>GREENSBORO, MD</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>1</u> p. m. <u>19</u>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town) (County) (State)   |   | 20g. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Jan. 10</u> , 19 <u>57</u> , to <u>Dec. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 29</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>1/2/58</u>  |   |   |   |
| ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.   |   | DATE SIGNED <u>1/2/58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |   | 22b. DATE THEREOF<br><u>JAN 3, 1957</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>CONCORD</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>CONCORD MD</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J VIRGIL MOORE</u>  |   | 24a. REC'D BY REGISTRAR<br><u>J. Mac Pippin</u>   |   |
| ADDRESS<br><u>5800 DENTON</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>J. Mac Pippin</u>  |   |
| DATE<br><u>JAN 6 1958</u>  |   | DATE<br><u>JAN 6 1958</u>   |   |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12925

12932

CERTIFICATE OF DEATH

Reg. Dist. No. 64

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston - Rural</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Harmony</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alfred</b> Middle <b>Elwood</b> Last <b>Kemp</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>14</b> Year <b>19 57</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 25, 1897</b>                                     |  |
| 9. AGE (In years last birthday) yrs.<br><b>60</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Saw Mill</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Caroline County, Md.</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>August D. Kemp</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Willoughby</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>    |  | 17. INFORMANT<br>Address<br><b>Mrs. Mollie Kemp, Preston, Md., R.F.D.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis - Coronary</b><br>DUE TO<br>(c) <b>Heart Disease</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>6/1/1956</b> to <b>Dec 14, 1957</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>57</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Federalburg, Md.</b> DATE SIGNED <b>Dec. 17, 1957</b>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Frank M. Anderson</b> M.D.   |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Frank M. Anderson, M.D.</b>   |  |   |  | <b>Federalburg, Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Dec. 17, 1957</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hill Crest Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Federalburg, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalburg, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>Dec 17, 1957</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Margaret H. Frampton</b>                     |  |

CERTIFICATE OF DEATH

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>[Faint text]                      |  | 2. SEX<br>[Faint text]                                 |  | 3. AGE<br>[Faint text]                            |  |
| 4. DATE OF DEATH<br>[Faint text]                         |  | 5. TIME OF DEATH<br>[Faint text]                       |  | 6. PLACE OF DEATH<br>[Faint text]                 |  |
| 7. CAUSE OF DEATH<br>[Faint text]                        |  | 8. MANNER OF DEATH<br>[Faint text]                     |  | 9. MEDICAL HISTORY<br>[Faint text]                |  |
| 10. HISTORY OF PRESENT ILLNESS<br>[Faint text]           |  | 11. HISTORY OF PREVIOUS ILLNESSES<br>[Faint text]      |  | 12. HISTORY OF SURGERY<br>[Faint text]            |  |
| 13. HISTORY OF TRAUMA<br>[Faint text]                    |  | 14. HISTORY OF TOBACCO USE<br>[Faint text]             |  | 15. HISTORY OF ALCOHOL USE<br>[Faint text]        |  |
| 16. HISTORY OF DRUG USE<br>[Faint text]                  |  | 17. HISTORY OF RACIAL OR ETHNIC ORIGIN<br>[Faint text] |  | 18. HISTORY OF OCCUPATION<br>[Faint text]         |  |
| 19. HISTORY OF EDUCATION<br>[Faint text]                 |  | 20. HISTORY OF MARRIAGE<br>[Faint text]                |  | 21. HISTORY OF CHILDREN<br>[Faint text]           |  |
| 22. HISTORY OF SOCIAL HISTORY<br>[Faint text]            |  | 23. HISTORY OF PERSONAL HISTORY<br>[Faint text]        |  | 24. HISTORY OF FAMILY HISTORY<br>[Faint text]     |  |
| 25. HISTORY OF PHYSICAL EXAMINATION<br>[Faint text]      |  | 26. HISTORY OF LABORATORY EXAMINATIONS<br>[Faint text] |  | 27. HISTORY OF X-RAY EXAMINATIONS<br>[Faint text] |  |
| 28. HISTORY OF PATHOLOGICAL EXAMINATIONS<br>[Faint text] |  | 29. HISTORY OF TREATMENT<br>[Faint text]               |  | 30. HISTORY OF FOLLOW-UP<br>[Faint text]          |  |

BUREAU V. S.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12926

12933

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CAROLINE</b> <b>MARYLAND</b>  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>CAROLINE</b>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>  |                           | c. LENGTH OF STAY IN 1b <b>LIFE</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 DENTON</b>   |                           | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   |
| d. STREET ADDRESS <b>1</b>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>EMMANUEL</b> <b>LANE</b>  |                           | 4. DATE OF DEATH<br>Month <b>DEC</b> Day <b>21</b> Year <b>1957</b>   |   |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 18, 1881</b> |
| 9. AGE (In years last birthday) yrs. <b>76</b>  |                           | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FISHERMAN</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>COM. FISHING</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |
| 13. FATHER'S NAME <b>WILLIAM LANE</b>   |                           | 14. MOTHER'S MAIDEN NAME <b>JULIA MONTAGUE</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <b>MRS MARY SCURTO</b> Address <b>DENTON, MD.</b>   |                           |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Coronary Insufficiency</b><br>DUE TO (c) |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>Few Minutes</b><br><b>2 years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Mch 22</b> , 19 <b>57</b> , to <b>Dec 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 21</b> , 19 <b>57</b> , and that death occurred at <b>4:09 P</b> M, from the causes and on the date stated above.   |                           |   |   |
| ACTUAL SIGNATURE <b>E. Paul Knotts</b> M.D.   |                           | ADDRESS (Street, city or town, state) <b>Denton Md</b>  |   |
| DATE SIGNED   |                           |   |   |
| PHYSICIAN'S NAME (Type) <b>E. Paul Knotts MD</b>  |                           | <b>Denton, Md</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                           | 22b. DATE THEREOF <b>DEC 24, 1957</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>  |                           | 22d. LOCATION (City, town, or county) (State) <b>DENTON MD</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Vi Vaughn</b> ADDRESS <b>more for Denton</b>  |                           | 24a. REC'D BY REGISTRAR <b>DATE 1/23/57</b>   |   |
| 24b. REGISTRAR'S SIGNATURE <b>Dr. George</b>  |                           |   |   |



12934

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

|   |                               |  |                                   |   |   |   |                  |
|---|-------------------------------|--|-----------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> <b>MARYLAND</b>  |                               |  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>  |                               |  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b> <b>x 2</b>                                  |   |   |                  |
| c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>   |                               |  |                                   | d. STREET ADDRESS <b>None</b> <b>1</b>  |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>  |                               |  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |                  |
| 3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>A.</b> Last <b>Lewis</b>  |                               |  |                                   | 4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>1957</b>   |   |   |                  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1/17/1876</b> | 9. AGE (In years last birthday) <b>81</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |                                   | 11. BIRTHPLACE (State or foreign country) <b>Penna.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                |                  |
| 13. FATHER'S NAME <b>Levi Zehner</b>  |                               |  |                                   | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Houser</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                   | 17. INFORMANT <b>Bessie Towers</b> Address <b>Denton, Maryland</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br><b>260x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (c) <b>DIABETES MELLITUS</b> |                               |  |                                   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b><br><b>10 YRS</b>           |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                   |   |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                               |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |                  |
|   |                               |  |                                   | 20f. (City or town) (County) (State)  |   |   |                  |
| 21. I certify that I attended the deceased from <b>JUNE 10, 1955</b> , to <b>DEC 12, 1957</b> , that I last saw the deceased alive on <b>DEC 28, 1957</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Greensboro, MD</b> DATE SIGNED <b>12/30/57</b>                              |                               |  |                                   |   |   |   |                  |
| ACTUAL SIGNATURE <b>Charles H. Stonecipher M.D.</b>   |                               |  |                                   | PHYSICIAN'S NAME (Type) <b>CHARLES H STONECIPHER M.D.</b>   |   |   |                  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>1/1/58</b>  |                                   | 22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>  |   | 22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b> ADDRESS <b>Greensboro, Md.</b>  |                               |  |                                   | 24a. REC'D BY REGISTRAR <b>DATE 12/31/57</b>  |   | 24b. REGISTRAR'S SIGNATURE <b>Wm D O George</b>                           |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form No. 10

|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|---------------------|--|--------|--|---------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|-------------------|--|--------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of Deceased |  | 2. Sex |  | 3. Race |  | 4. Date of Birth |  | 5. Date of Death |  | 6. Place of Birth |  | 7. Usual Residence |  | 8. Cause of Death |  | 9. Manner of Death |  | 10. Signature of Physician |  | 11. Signature of Registrar |  | 12. Date of Registration |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|                     |  |        |  |         |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
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## CERTIFICATE OF DEATH

12935

Reg. Dist. No. 100

|  |                                 |  |                                     |   |   |  |  |
|--|---------------------------------|--|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Caroline</b> <b>MARYLAND</b>   |                                 |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Marydel</b>   |                                 |  |                                     | c. LENGTH OF STAY IN 1b<br><b>70 Yrs.</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>None</b>  |                                 |  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Thomas</b> Last <b>Martin</b>  |                                 |  |                                     | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>16</b> Year <b>19 57</b>   |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Col.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/4/1880</b> | 9. AGE (In years last birthday)<br><b>77</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. | IF UNDER 24 HRS.<br>Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farm Laborer</b>   |                                 |  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                     |  |
| 13. FATHER'S NAME<br><b>William T. Martin</b>  |                                 |  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Emory</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                 |  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Cora Wells</b> Address <b>1232 Walnut Street Wil.Del.</b>                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular</b><br>DUE TO (c) <b>Disease</b> |                                 |  |                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |                                     |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. <b>19</b> p. m.   |                                 |  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Greensboro, Md.</b> |  |
| 20f. (City or town)<br><b>Greensboro, Md.</b>  |                                 |  |                                     | 20g. (County)<br><b>Greensboro, Md.</b>   |   | 20h. (State)<br><b>Md.</b>   |  |
| 21. I certify that I attended the deceased from <b>Dec. 15, 1957</b> , to <b>Dec. 16, 1957</b> , that I last saw the deceased alive on <b>Dec. 16, 1957</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.   |                                 |  |                                     |   |   |  |  |
| ACTUAL SIGNATURE <i>Charles H. Stonesifer</i> M.D.   |                                 |  |                                     | DATE SIGNED <b>12/18/57</b>   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>   |                                 |  |                                     |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 22b. DATE THEREOF<br><b>12/20/57</b>   |                                     | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Marydel, Maryland</b>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>J. E. Boulaie</i>   |                                 |  |                                     | ADDRESS<br><b>Greensboro, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>12/20/57</b>   |  |
|  |                                 |  |                                     | 24b. REGISTRAR'S SIGNATURE<br><i>A. Clark Smith</i>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 26 1957

RECEIVED

## 12936 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Caroline</b><br>MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Templeville</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>Templeville</b> <b>x2</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>None</b>   |                                      | d. STREET ADDRESS<br><b>None</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Laura</b> Middle <b>McKnett</b> Last <b>McKnett</b>  |                                      | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>13</b> Year <b>1957</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/13/1872</b>   |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.   |                                      | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |   |   |
| 13. FATHER'S NAME<br><b>Isaac Moore</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>No Record</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes or unknown) <b>No</b> (If yes, give war or dates of service)   |                                      | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Robert McKnett Templeville, Md.</b>                         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis (generalized)</b><br>DUE TO (c) _____ |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b><br><b>10 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>chr. hepatitis</b>  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>no injury</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____ |
| 20f. (City or town)<br>_____ (County) _____ (State) _____   |                                      |   |   |
| 21. I certify that I attended the deceased from <b>Oct 1952</b> , to <b>Dec 13, 1957</b> , that I last saw the deceased alive on <b>Dec 10, 1957</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above.   |                                      |   |   |
| ACTUAL SIGNATURE <b>H. H. Hamilton</b>  |                                      | M.D. <b>Millington Md</b> DATE SIGNED <b>12/14/57</b>   |   |
| PHYSICIAN'S NAME (Type) <b>H. H. HAMILTON</b>   |                                      |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>12/16/57</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Templeville</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Templeville, Maryland</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. E. Borelains Greensboro, Md.</b>  |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>12/17/57</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>A. Clark Smith</b>                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                        |  |                      |  |                       |  |                          |  |                    |  |                     |  |                           |  |
|------------------------|--|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|--------------------|--|---------------------|--|---------------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE                  |  | DATE OF BIRTH         |  | PLACE OF BIRTH           |  | CITY               |  | STATE               |  | COUNTRY                   |  |
| JAMES EARL RAY         |  | MALE                   |  | 35                   |  | JAN 5 1928            |  | MOBILE, ALABAMA          |  | MOBILE             |  | ALABAMA             |  | UNITED STATES             |  |
| RACE                   |  | COLOR                  |  | RELIGION             |  | MARRIAGE              |  | EDUCATION                |  | OCCUPATION         |  | CAUSE OF DEATH      |  | MANNER OF DEATH           |  |
| WHITE                  |  | WHITE                  |  | METHODIST            |  | MARRIED               |  | HIGH SCHOOL              |  | LABORER            |  | HEART DISEASE       |  | NATURAL                   |  |
| DATE OF DEATH          |  | PLACE OF DEATH         |  | CITY                 |  | STATE                 |  | COUNTRY                  |  | DATE OF BURIAL     |  | PLACE OF BURIAL     |  | CITY                      |  |
| DEC 13 1967            |  | BALTIMORE              |  | BALTIMORE            |  | MD                    |  | USA                      |  | DEC 15 1967        |  | BALTIMORE           |  | BALTIMORE                 |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESS |  | SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF CLERK |  | SIGNATURE OF CHURCH |  | SIGNATURE OF FUNERAL HOME |  |
| [Signature]            |  | [Signature]            |  | [Signature]          |  | [Signature]           |  | [Signature]              |  | [Signature]        |  | [Signature]         |  | [Signature]               |  |
| DATE                   |  | TIME                   |  | PLACE                |  | CITY                  |  | STATE                    |  | COUNTRY            |  | CITY                |  | STATE                     |  |
| DEC 13 1967            |  | 10:00 AM               |  | BALTIMORE            |  | BALTIMORE             |  | MD                       |  | USA                |  | BALTIMORE           |  | BALTIMORE                 |  |

BUREAU V. S.

DEC 20 1967

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12937

12930

Reg. Dist. No.

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Marydel</b><br>c. LENGTH OF STAY IN 1b <b>2 5 Yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Marydel</b> <b>x 2</b><br>d. STREET ADDRESS <b>None</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>A.</b> Last <b>Miller</b>   |                               | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>31</b> Year <b>1957</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>8/24/1883</b>                 |
| 9. AGE (In years last birthday) <b>74</b> yrs.  |                               | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>1</b>   | IF UNDER 24 HRS.<br>Hours <b>1</b> Min. <b>57</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio Repair</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Radio Repair</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Ohio</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Joushia M. Miller</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Sarah A. Waverwright</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |   |
| 17. INFORMANT <b>Anna Miller</b>  |                               | Address <b>Marydel, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO <b>Coronary Sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b><br>DUE TO (c) <b>?</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>                              |                               |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>  |                               |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year <b>19</b><br>Hour <b>a. m.</b> p. m.  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                               |  |   |
| ACTUAL SIGNATURE <b>Dawson O. George</b>  |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>Dawson O. George</b>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               | DATE SIGNED <b>12-31-57</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>1/5/58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Gravel Lawn</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Pendleton, Indiana</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais Greensboro, Mel.</b>  |                               | ADDRESS <b>Greensboro, Mel.</b>  |   |
| 24a. REC'D BY REGISTRAR <b>J. E. Boulais</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>J. E. Boulais</b>  |   |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1933

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12931

Reg. Dist. No. 62

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Denton</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>5 years</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>x2 Denton</b>           |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sixth Street</b>  |                                  |   | d. STREET ADDRESS<br><b>318 S. Fifth Avenue</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Georgia</b> Middle <b>Ann</b> Last <b>Trice</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>17</b> Year <b>1957</b>  |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 25, 1875</b>  | 9. AGE (In years last birthday)<br><b>82 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>IF UNDER 24 HRS.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Caroline Co., Maryland</b>                                     |   |
| 13. FATHER'S NAME<br><b>George W. Towers</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Julia E. Liden</b>  |                                  |   |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Miss J. Lillian Towers, Denton, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocarditis Acute</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Myocarditis Chronic</b><br>(c) DUE TO<br>cause lost.   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |   |  |   |
| ACTUAL SIGNATURE <b>Dawson O. George</b>   |                                  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |
| EXAMINER'S NAME (Type) <b>Dawson O. George</b>   |                                  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |
|  |                                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Dec. 20, 1957</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Concord Cemetery</b>  |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Near Federalsburg, Maryland</b>  |                                  |   |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |                                  |   | ADDRESS<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>12/19/57</b>   |
|  |                                  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Dawson O. George</b>   |  |   |

DATE SIGNED

12-19-57

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                  |  |                |  |                          |  |                            |  |                         |  |                          |  |
|------------------|--|----------------|--|--------------------------|--|----------------------------|--|-------------------------|--|--------------------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX                      |  | RACE                       |  | DATE OF DEATH           |  | PLACE OF DEATH           |  |
| JAMES J. JONES   |  | 45             |  | M                        |  | W                          |  | JAN 15 1927             |  | BOSTON, MASS.            |  |
| RESIDENCE        |  | OCCUPATION     |  | EDUCATION                |  | MARRIAGE                   |  | PREVIOUS ILLNESS        |  | CAUSE OF DEATH           |  |
| 1234 BROADWAY    |  | Carpenter      |  | High School              |  | Married                    |  | Pneumonia               |  | Pneumonia                |  |
| DATE OF BIRTH    |  | PLACE OF BIRTH |  | DATE OF ENTRY INTO STATE |  | DATE OF ENTRY INTO COUNTRY |  | DATE OF ENTRY INTO CITY |  | DATE OF ENTRY INTO STATE |  |
| JAN 15 1882      |  | MASSACHUSETTS  |  | JAN 15 1920              |  | JAN 15 1920                |  | JAN 15 1920             |  | JAN 15 1920              |  |
| DATE OF DEATH    |  | PLACE OF DEATH |  | DATE OF DEATH            |  | PLACE OF DEATH             |  | DATE OF DEATH           |  | PLACE OF DEATH           |  |
| JAN 15 1927      |  | BOSTON, MASS.  |  | JAN 15 1927              |  | BOSTON, MASS.              |  | JAN 15 1927             |  | BOSTON, MASS.            |  |

BUREAU V. 1

EC 23 1927

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |   |   |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |   |   |   |   |   |   |  |  |  |
| Reg. Dist. No. 12932  |  |   |   |   |   |   |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b><br>MARYLAND  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg - Rural</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>6 years</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X/ Federalsburg - Rural</b>                          |   |   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Near Concord</b>   |  |   |   |   | d. STREET ADDRESS<br><b>/ Near Concord</b>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Robert</b> Middle <b>Bowdle</b> Last <b>Trice</b>  |  |   |   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>24</b> Year <b>19 57</b>   |   |   |   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                              |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>April 16, 1885</b>     |   | 9. AGE (In years last birthday)<br><b>72 yrs.</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Bus Operator for Public Service Corp.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Caroline Co., Md.</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |   |  |  |  |
| 13. FATHER'S NAME<br><b>John Trice</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>139-05-1471</b>                 |   | 17. INFORMANT<br>Address <b>Mrs. Marie T. Trice, Federalsburg, Md., R.F.D.</b>  |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Skull Fracture - Fractured Legs</b><br><b>812X</b> DUE TO <b>Internal Injuries</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Internal Injuries</b> DUE TO (c) <b>Internal Injuries</b>   |  |   |   |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>suicide</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Run down by Automobile</b> |   |   |   |   |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>8:36</b> a.m. <b>12/24 1957</b> p.m.   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>          |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway 313</b>  |   | 20f. (City or town)<br><b>Rural Denton Caroline Md</b>        |   | (County)<br><b>Caroline</b> (State)<br><b>Md</b>   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |   |   |   |   |   |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |   |   | 22b. DATE THEREOF<br><b>Dec. 28, 1957</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Concord Cemetery</b> |   |  | 22d. LOCATION (City, town, or county)<br><b>Near Federalsburg, Maryland</b> (State)<br><b>Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>  |  |   |   |   | ADDRESS<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 12/27/57</b>               |   | 24b. REGISTRAR'S SIGNATURE<br><b>Mr. D. George</b> |  |  |



DEC 31 1957

RECEIVED

12940

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|  |                                  |   |  |   |  |  |  |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> <b>MARYLAND</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Greensboro</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>50 Yrs.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>None</b>  |                                  |   |  | e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Roland</b> Middle <b>Marshal</b> Last <b>Walls</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>15</b> Year <b>19 57</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/14/1904</b>                 |   | 9. AGE (In years last birthday)<br><b>53</b> yrs.          | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer Christler Corp.</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b> |  |  |
| 13. FATHER'S NAME<br><b>Louis Walls</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Bloxton</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-14-6749</b>   |  | 17. INFORMANT<br><b>Anna Walls Greensboro, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung (left)</b><br><b>163X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <b>51</b> p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Aug. 10, 19 57</b> , to <b>Dec. 15, 19 57</b> , that I last saw the deceased alive on <b>Dec. 15, 19 57</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b> DATE SIGNED <b>12/17/57</b>  |                                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.   |                                  |   |  | DATE SIGNED <b>12/17/57</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>   |                                  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/18/57</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greensboro</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Greensboro, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. E. Boulaiss</b>  |                                  |   |  | ADDRESS<br><b>Greensboro, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>12/18/57</b>                              |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>L. Mu. Pippin</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                  |  |                |  |                |  |                |  |                |  |                 |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |
|------------------|--|----------------|--|----------------|--|----------------|--|----------------|--|-----------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX            |  | RACE           |  | DATE OF BIRTH  |  | PLACE OF BIRTH  |  | CITY OF BIRTH        |  | STATE OF BIRTH       |  | COUNTRY OF BIRTH     |  | DATE OF DEATH        |  | PLACE OF DEATH       |  | CITY OF DEATH        |  | STATE OF DEATH       |  | COUNTRY OF DEATH     |  |
| JAMES EARL RAY   |  | 35             |  | M              |  | W              |  | 1928           |  | MEMPHIS         |  | TENNESSEE            |  | TENNESSEE            |  | UNITED STATES        |  | APRIL 4, 1968        |  | MEMPHIS              |  | TENNESSEE            |  | UNITED STATES        |  | UNITED STATES        |  |
| OCCUPATION       |  | EDUCATION      |  | MARRIAGE       |  | RELIGION       |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  | CERTIFICATE OF DEATH |  |
| ATTORNEY         |  | HIGH SCHOOL    |  | MARRIED        |  | METHODIST      |  | HEART DISEASE  |  | SUICIDE         |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  | MAY 1, 1968          |  |
| SIGNED           |  | SIGNED         |  | SIGNED         |  | SIGNED         |  | SIGNED         |  | SIGNED          |  | SIGNED               |  | SIGNED               |  | SIGNED               |  | SIGNED               |  | SIGNED               |  | SIGNED               |  | SIGNED               |  | SIGNED               |  |
| JAMES EARL RAY   |  | JAMES EARL RAY |  | JAMES EARL RAY |  | JAMES EARL RAY |  | JAMES EARL RAY |  | JAMES EARL RAY  |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  | JAMES EARL RAY       |  |

RECEIVED  
DEC 9 1967  
BUREAU V. S.